October 7, 2004

MDR Tracking #: M2-05-0057-01
IRO Certificate #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in Physical Medicine and Rehabilitation. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Records supplied for review in this case include a 12/11/03 IME by ___, office notes, op reports, request for services from ___ from 12/03 to 07/04, consult with ___, psychological evaluation by ___. LPCi, and two denial letters from ___.

CLINICAL HISTORY

This 53-year-old gentleman was lifting a windowpane with a co-worker when the pane broke and he sustained deep lacerations to his left forearm. He was taken to the OR. ___, plastic surgeon, repaired extensive lacerations to the muscles, radial nerve and radial artery. Post op he continued to have pain and weakness in the left arm. Medications did not control his pain. He was diagnosed with RSD and given several stellate ganglion blocks with only transient relief. He also had neurolysis and release of the median nerve with only temporary relief. He was given a trial of a spinal cord stimulator by ___ which gave relief for only three days. He was then offered a morphine pump, the trial of which was considered successful. Percutaneous permanent placement of the morphine pump was attempted but was not successful due to no fluid collecting in the tubing. Open incision insertion of the tubing was requested but declined by the patient. During post injection procedures he required a blood patch. A chronic pain management program was requested by ___, but the carrier denied the program, stating that there were two treatment programs in progress – insertion of morphine pump and a chronic pain management program.

REQUESTED SERVICE

A 30-session chronic pain management program is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The carrier appears to have made a decision without the knowledge that the patient had failed an attempt to

insert the morphine pump and decided against having the pump inserted. ___'s request for a chronic pain management program is the next logical step, and is the accepted standard of care for this injured worker. His request was not a poorly coordinated care issue, as stated by the carrier's physician, but a make by the reviewer not being provided with the latest medical documentation.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 7th day of October, 2004.